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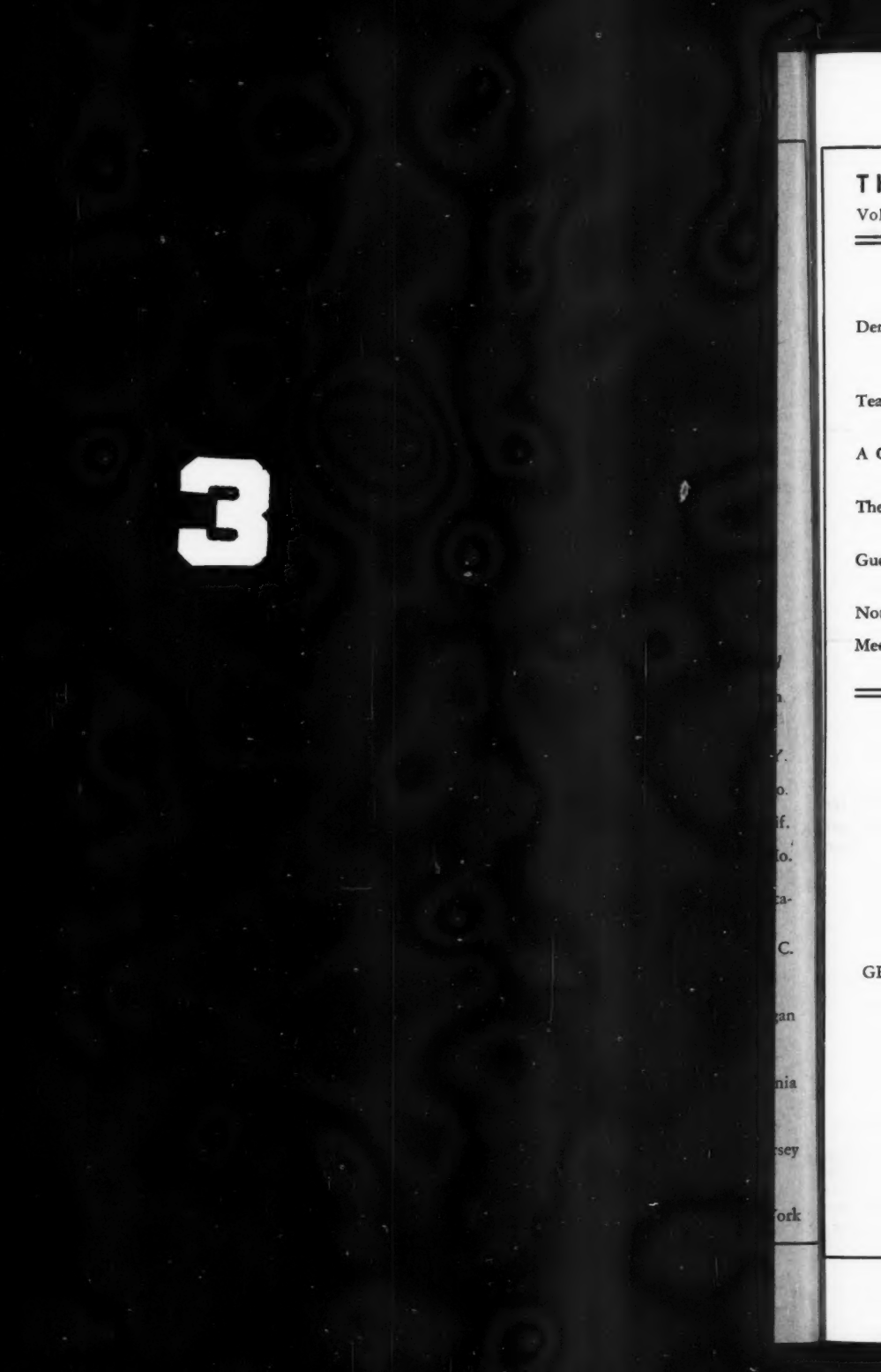
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Editor-in-Chief
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Chicago, Ill.

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THE JOURNAL OF SCHOOL HEALTH

Devoted to the interests and advancement of school health service and instruction. Your participation by membership is solicited.

Vol. XXV MARCH, 1955 No. 3

A DENTAL HEALTH PROGRAM IN A LARGE MIDWEST SCHOOL SYSTEM

HERMAN N. BUNDESEN, M.D.
President, Chicago Board of Health
JOHN C. BERGMANN, M.Sc., D.D.S.
Chief—Dental Health Section, Chicago Board of Health

"Health is a continuing process of adjusting one's self to one's environment and to one's associates." This is the statement of Dr. Benjamin C. Willis, General Superintendent of Chicago's Public Schools, in the Foreword of "Living With Yourself and Others."* He further states that "the total school environment, the understanding and support of all school personnel, and the use of the health education potentials in the school, the home and the community strongly influence the effectiveness of teaching and learning in the area of health."

In the dental health education program now operating in the public elementary schools of Chicago, we have such a cooperative community health endeavor. This program was planned by a committee consisting of representatives of the Chicago Dental Society, the Board of Health, the Board of Education, and the three University Dental Schools, located in Chicago, and this Committee exercises general supervision over the program. Approximately 150,000 children have participated in the program since its inception in September, 1949.

The modus operandi is as follows: The staff consists of dentists, members of the Chicago Dental Society, civil service staff dentists of the Chicago Board of Health, and dental hygienists from Northwestern University, specifically trained for participation in this program. And last, but not the least important, are principals and classroom teachers who have been instructed for their role in the program through indoctrination meetings with dentists and hygienists assigned to the project.

Inspections are made by dentists, using mouth mirrors and explorers, and data obtained from these inspections is recorded as part of the health record of each child. In addition, the hygien-

*A Teacher's Guide to Health Education—published by the Department of Instruction and Guidance in cooperation with the Department of Secondary Education, Chicago Public Schools, 1954.

ists talk to the children in each room of every school participating in the program.

The educational impact of the whole program can be resolved into four fundamental and basic health rules. These rules are preventive measures, substantiated by authentic research, which, if practiced by children, will materially reduce the incidence of caries.

They are as follows:

(1) *Brush the teeth immediately after each meal* and before going to bed. If this cannot be done, the child should rinse his mouth with water.

Dr. Fosdick of Northwestern University, in his caries research, has demonstrated that decay can be reduced approximately 50% through this practice.

(2) *Eat an adequate amount of protective foods,* such as milk, fruits, vegetables, eggs, meat, whole grain cereals and bread. If children are hungry between meals, give them fruit juices, fresh fruits, nuts, popcorn, milk or cheese, instead of candy, gum, pop or other sweets.

There is a common premise in research that claims reduction of dental caries by means of the reduction of the intake of sugar in the diet. If children adhere to this practice, they reduce the frequency of the caries attacks in their mouths and thereby reduce the amount of caries.

(3) *Children should have their teeth treated with sodium flouride by a dentist.* Reliable research shows that by topical application of fluoride, caries can be reduced approximately 40%.

(4) The fourth rule is that *each child should consult the dentist as frequently as the dentist advises.* Usually this is at least twice a year. By adhering to this program, he gets periodic maintenance care which is essential to mouth health.

The classroom teacher continues this educational process through the use of a teaching outline, for her grade level, and other supplementary materials left with her. She also receives a teacher's score sheet, on which each pupil's name is listed, with those children needing care indicated in a special column. Additional information is obtained from time to time by the classroom teacher, such as, initial appointment with dentist, progress reports, and ultimate completion of work, indicated by signed statements of dentists rendering this service.

Educational pamphlets are left with the classroom teachers together with instructions on distribution to the parents. These

pamphlets are for parent contact and education, together with publicity and aid of the local P.T.A. This procedure has been most effective.

TABLE I — SUMMARY
DENTAL HEALTH EDUCATION PROGRAM
SEPTEMBER 1953 — JUNE 1954

	1st grade		5th grade	
	No.	Rate	No.	Rate
Total Children in rooms	17,060		11,260	
Total Children Inspected	15,030	1.0	10,621	1.0
Children Needing Dental Care	9,767	.65	7,216	.68
Children with Permanent Teeth Involvement				
*Carious	6,042	.40	15,292	1.44
*Filled	1,345	.09	14,823	1.40
*Extracted	353	.02	2,294	.22
Oral Hygiene	1st & 5th Grades			
Good	10,647	.42		
Fair	10,206	.40		
Poor	4,798	.19		

Progress Report as reported 6-15-54:
1st Grade: In progress or completed 36%
5th Grade: In progress or completed 43%
*D.M.F. data—(Decayed, Missing, and Filled Teeth.)

Integrated with our dental health education program is our dental care program. It has been stated that any progressive dental health program is a triangular structure, the three sides of which are *research, service* and *education.* Lacking any one of its parts, the triangle collapses. If research data are not available, education will lack validity. Dental services unaccompanied by education, explaining the reasons for the services, cannot bring about their intelligent use. The Chicago program combines research, service and education to give it balance, which is so essential. In a typical public health approach, the Board of Health has assumed responsibility for services and research, the Board of Education supplies the facilities and the educational materials and teaching personnel, — the latter through the Division of Health and Physical Education, together with the cooperation of the Bureau of Health Services; and the Chicago Dental Society, through its Committee on Dental Health Education, supplies materials and personnel to the program. At this point I should like to report briefly a summary of services rendered to indigent school children during the school year of September 1953 to June 1954.

TABLE II — CHICAGO BOARD OF HEALTH
DENTAL HEALTH SERVICE REPORT
SCHOOL YEAR SEPTEMBER 1953 TO JUNE 1954

Child Visits to Clinics	46,406	
New Cases	10,353	
Re-Visit Cases	27,446	
Emergency Cases	1,624	
Completed Cases	6,983	46,406
Treatments:		
First Molars Saved	9,979	
Prophylaxis	10,643	
Anodyne	2,228	
Treatment of Abscess	330	
Zinc-Oxide Eugenol	1,766	
Sodium Fluoride	10,592	35,538
Fillings:		
Silver Amalgam	37,136	
Oxyphosphate of Zinc	5,589	
Silicate	3,290	46,015
Extractions:		
Deciduous Teeth	8,262	
Permanent Teeth	2,866	11,128

Conclusions

The dental needs of an area will vary with the disparity between its "potential" and "effective demands." Potential demand expresses a desire for dental service. Effective demand includes, desire for dental service, plus the ability to obtain that service. An evaluation of the effectiveness of any program can be measured by examining the *D.M.F.* data.*

Using the First Grade figures of our Chicago program, we find the filled-carious ratio to be 1,345:6,042, which means that first permanent molars are *decaying at a rate 5 times faster than they are being filled,* and this is identical with the national level of caries experience. The extracted-filled ratio is 353:1,345 which means that approximately *one permanent tooth is extracted, for every four filled,* or a *tooth mortality of 25% of the filled rate.*

On the fifth grade level the filled-carious ratio is 14,823:15,292, which means *approximately one filled permanent tooth for each carious one, a much better ratio of dental care to dental need,* than we found in the data for the first grade level. The filled-extracted ratio, is 14,823:2,294, which means the extracted rate is 1/7 that of the filled rate, or *a tooth mortality rate, of one lost for every seven filled.* Logically, it can be assumed that a considerable portion of this evidenced improvement in dental health at the 5th grade level results from the educational experiences of these children since their initial contact with the program as first graders.

*D.M.F. data—See reference in Table I.

Chicago's dental problems are identical with those of other American Cities.

1. Shortage of dentists, nurses and hygienists. (More trained personnel needed.)
2. Shortage of effective education regarding the value of dental care. (We as a Nation spend one billion dollars a year for dentistry, and many times this amount for cosmetics, tobacco and alcohol.)
3. The rapid accumulation of dental defects.
4. Parental apathy or indifference.
5. Misconception of the value of dental care for children.
6. Economic factors.

All of these play a part in the total dental picture of school-age children.

* * * * *

1955 HEART FUND DRIVE

With the broad expansion of its national research program as its leading objective, the American Heart Association and its affiliates today launched the month-long 1955 Heart Fund Campaign throughout the nation under the chairmanship of General Mark W. Clark, former U. S. Commander-in-Chief in the Far East. The Heart Fund is the annual public appeal through which the Heart program is made possible.

The drive, seventh since the American Heart Association became a national voluntary health organization in 1948, is being conducted in more than 3,000 communities under the guidance of 56 affiliates and 350 chapters. "Help Your Heart Fund, Help Your Heart" is the slogan of the 1955 campaign.

In opening Heart Month, General Clark pointed out that the heart diseases account for nearly 800,000 deaths in the United States each year — more than all other causes combined. Some 10,000,000 Americans, including 500,000 children, suffer from some sort of heart or blood vessel disease, he said.

* * * * *

TEACHING ASSISTANTSHIPS IN HEALTH EDUCATION

Eight (8) quarter-time Teaching Assistantships are open to properly qualified graduate students who wish to work toward the degree Master of Science in Health Education at the University of Illinois during the 1955-56 school year. These Assistantships carry a stipend of $750.00 for the school year, plus free tuition.

Students interested in applying should write directly to Dr. Howard S. Hoyman, Professor of Health Education, University of Illinois, Urbana, Illinois, for information and application forms.

TEAM WORK FOR SCHOOL HEALTH

HESTER BETH BLAND, Consultant
Division of Health and Physical Education
Indiana State Board of Health
ROBERT YOHO, Director
Division of Health and Physical Education
Indiana State Board of Health

Since the beginning of the hot lunch program in Indiana Public Schools, the Indiana State Board of Health has had many requests from school administrators and P.T.A. organizations for information relative to the correct handling, preparation, and serving of foods. It has given liberally of its time, inasmuch as the enforcement of the sanitary code for preparation, handling, and serving of food in all eating establishments is a responsibility of the Board. Out of these requests grew the recognition of a need for a plan of improving the conditions under which the lunch program is conducted so that the school children of Indiana would be assured nutritious food in accordance with the best sanitary standards.

The inauguration of the school lunch improvement program was accomplished through institutes designed to acquaint administrators, home economics teachers, cooks, food handlers, janitors, etc., with the problems involved in the management and conduct of school lunch programs. The institutes, as well as other phases of the program, were a cooperative endeavor between the State Board of Health and the State Department of Public Instruction, (the agency that administers the Federal School Lunch Program.)

If inspection of eating establishments as a means to better sanitary conditions is necessary in the restaurant across the street, or downtown, why not in the school buildings where the hot lunch programs are in existence? With this in mind, it seemed logical to help the schools establish the same sanitary conditions required of Grade A restaurants. Again cooperation was an important item. The School Lunch Division of the State Department of Public Instruction was eager to have inspections made. It followed logically, therefore, that trained and experienced personnel of the Indiana State Board of Health should undertake the inspection since its qualified sanitarians were already in the field doing this work.

It was agreed from the beginning that the usual type of inspection would not accomplish the desired results. Contacts with

school lunch personnel would have to be more in the nature of educational visits. Thus improvement would result, not because a higher authority so dictated, but because proper storage, refrigeration, handling and serving of food would contribute to the welfare of the school child. Everyone involved in the program recognized that such an approach would be time consuming but they believed greater benefits would result in the long run.

Obviously, if there is need for improving conditions associated with the lunch program it is reasonable to assume that there may be other sanitary conditions in the school environment that need attention. Too, only approximately one-half hour within the eight hour school day is spent in the lunch room, so it seemed entirely inconsistent to limit the inspection to the lunch room. Since other sanitary conditions might need attention, the areas were expanded to include: (1) sewage disposal; (2) water supply; (3) lunch room; (4) general housekeeping; (5) building construction. Although these do not represent the entire field of school sanitation, they are basic and could be evaluated in the time allotted. Since the improvement program would extend beyond the confines of the lunch room, additional manpower with knowledge of standards in these additional areas was required. So, quite naturally, engineering personnel of the State Board of Health became involved in the project.

Most people are interested in doing a better job if they understand the reason for it. Certainly those school people responsible for the health and welfare, as well as the education, of boys and girls in Indiana, are eager to improve any school project that produces maximal benefits for children. But unless people are specially trained, they usually are not familiar with the requirements essential to providing safe food, a good water supply or adequate sewage disposal. Often the unfamilar may seem unnecessary; the difficult impossible. So the need for interpretation, a very important adjunct in bringing about change, loomed large and became the responsibility of the health education and public health nursing personnel of the Indiana State Board of Health. Here was opportunity for health education of a practical sort — making the project so vital it would sell itself.

"Inspection" is a harsh word with implications many times misunderstood and frequently resented. Since the purpose of the project was a program of improvement with no thought of retaliatory action, the term "inspection" was discarded — replaced by "School Health Survey."

After possibilities for doing the survey were carefully thought out, and when the philosophy underlying it was well understood, namely an improvement program, representatives of the three State Board of Health Divisions — Engineering, Food and Drugs, and Health Education — having conferred with the School Lunch Division of the State Department of Public Instruction, visited the branch offices of the State Board of Health. There they met the entire branch office staffs to explain the project. Great emphasis was placed upon the basic philosophy which should guide those working in the program — (1) that correction of improper conditions cannot and should not be forced upon the school people; (2) when they realize the benefits to be derived from improvement, they will work to secure such benefits for the children they serve. The specific planning and arranging of details related to the surveys were done by the branch office staffs and vary slightly in accordance with community needs, customs and experiences. Although there are slight deviations, in general the five branch offices use a pattern similar to the following.

The health educator, nurse or nutritionist contacts the county health officer and the county superintendent of schools to explain the reasons for the survey and to enlist their interest and support. Subsequently, this same person calls upon the school principal since he is responsible for the management of the school, and an approximate date for the survey is arranged. It is also suggested that the principal and the trustee accompany the individual making the survey. School administrators, once acquainted with objectives and the assistance available in carrying out their responsibilities in the program, frequently request such surveys.

Following the survey, a letter addressed to the principal contains the recommendations divided into two categories: (1) those that need immediate attention, such as refrigeration or methods of dishwashing; and (2) those that will be part of a long range program, — the addition of equipment, development of a new water supply, building program, etc. The tone of this letter indicates that the recommendations are made in the spirit of cooperation, hoping they will serve as the basis in improving the sanitary conditions within the school. There is no hint of policing action. Many of the recommendations involve considerable time and money and are fully understood and appreciated by the surveying agencies. All suggestions for changes are considered as constructive criticism intended to guide the school officials in doing things they are capable of doing to improve the school environment. They

are not official enforcement orders from a state agency. Copies of all letters are forwarded to the State Department of Public Instruction, the local health officer, township trustee, county or city superintendent of schools; and to others on special request of the school principal. Great care is taken to assure that information is given only to those individuals having direct responsibility for the administration of the school system.

After the recommendations are mailed, the person making the original contact with the principal does the follow-up and works with the principal, P.T.A., or other community groups to stimulate interest in getting the recommendations carried out. When lay people understand that the health of their children is involved, they are not only interested in seeing improvements made, but eager to support action to help bring about needed changes. This points up the importance of interpreting the situation to the community.

To have attempted the survey in all schools in Indiana with the present number of employees would have been folly, hence some limitation was necessary. Schools chosen for survey were those having the hot lunch program since they represent about eighty percent of the school population. Too, they present the immediate hazards attendant upon food handling and service.

Begun in 1951, the original plans called for repeated surveys every two years. In 1953 a method of scoring and recording was worked out to provide for objective evaluation. This presented a problem since no system was available for objective scoring with universally accepted criteria for rating in all areas to be surveyed. The Indiana State Board of Health Inspection Form for Public Eating and Drinking Establishments was accepted as the standard for rating in the area of food handling. Representatives of the participating divisions worked out the rating sheet and criteria for evaluation for the areas of: water supply, site, sewage disposal, building, lighting, heating and ventilation, and occupancy. At this date the method and procedure seem satisfactory.*

The survey was organized to coordinate and use the services and resources of various trained and experienced personnel. The follow-up is carried out in routine work with school people thus tying in the School Health Survey with other programs in the field of health. This plan makes possible a project for common good through continuous service and proves again the effectiveness of

*Requests for copies of "A School Survey" and "Criteria for School Rating System" may be addressed to the authors. Unfortunately, space for including these in The Journal was not available.

cooperation and understanding in programs designed for better health.

Experience in conducting the School Sanitation Survey as a part of a continuing state consultation service on school health points up specific advantages of this procedure. It provides rather convincing evidence of the value to be derived when state departments, and individuals or professions within departments, use the team approach in attacking school health problems.

* * * * *

NATIONAL CONFERENCE ON HEALTH EDUCATION WASHINGTON, D. C.

The American School Health Association was represented at the National Conference on the Undergraduate Health Education Minor and the Desirable Health Education Emphases for the Physical Education Major held in Washington, January 9-11, 1955. Dr. H. F. Kilander, ASHA President, was the Director of the Conference which was initiated by the American Association for Health, Physical Education and Recreation. Co-sponsors for the Conference were the American Association of Colleges for Teacher Education and the National Commission on Teacher Education and Professional Standards of the NEA. Eighteen other organizations cooperated in sending representatives.

The purpose of the Conference was to provide an opportunity for the participants to exchange ideas and viewpoints related to the health education minor. Invitations were sent to 97 colleges and universities. There were 86 persons in attendance, representing 25 states.

The opening session of the Conference was devoted to a summary of the pre-conference questionnaire findings and of recent surveys related to the subject of the Conference.

The participants were divided into four groups for the study of the major sub-problems. These topics were: (1) the health education minor curriculum; (2) health emphases in the physical education major; (3) interdepartmental relationships, teaching methods, student teaching and field experience, and (4) certification requirements, recruitment and placement.

The report of the Conference will be available in the near future from the National Office of the A. A. H. P. E. R. Dr. Elizabeth S. Avery, who served as Coordinator for the Conference Planning Committee is Chairman of the Editorial Committee for the published report.—*Elena M. Sliepcevich.*

A CHALLENGE TO COLLEGE ADMINISTRATORS*

JESSIE HELEN HAAG, Ed. D.
The University of Texas, Austin, Texas

School and community health programs depend upon the interest and coordinated functions of many persons. Parents, teachers, school administrators, physicians, dentists, nurses, public health educators, sanitary engineers, nutritionists, and workers in official and non-official health agencies must provide the teamwork necessary for effectively functioning school and community health programs. However, there are communities where elementary and secondary school health programs are barely evident and where public health measures gain little community support. Adult apathy, noticeable in some college graduates who are leaders in their communities, may be the result of ineffective health programs in institutions of higher learning. These health programs may offer little opportunity for continuous participation by the college student. If the undergraduate's experiences are limited in the college health program, he may acquire an apathy which can be detrimental to school and community health programs.

One might ask, when does the undergraduate participate in the college health program? His first introduction may be during freshmen week. At this time, he may or may not have a chest x-ray, a complete medical examination, a smallpox vaccination, and answer countless questions concerning his health history. Here is his first contact with the student health center and his first opportunity to become acquainted with the health services personnel.

During the same orientation week, the freshman needs considerable guidance. He has many questions to ask, has problems in adjusting to unfamilar surroundings, has difficulty in making friends, has a feeling of insecurity which might be the result of financial and/or religious problems, and has a feeling of uncertainty as to whether he has chosen the right field of study. Individually, the freshman needs assistance. Counselors, deans of student life, and faculty are over-worked during the orientation week.

During this period of orientation, the college freshman has his first impressions of his college environment. The environment includes the places where he lives, he dines, he engages in sports,

*Portions of this paper were presented at the Southwest section meeting, American College Health Association, Nov. 5, 1954, Dallas, Texas.

he enjoys his leisure time, he studies, he attends classes, he worships, and he meets his friends. In these surroundings, he can come in contact with unsanitary measures, accident hazards, faulty building construction, poor quality of lighting, fixed and unadjustable classroom seating, insufficient shower units and storage space, inadequate facilities for intramurals and regularly scheduled physical education classes, and faulty equipment in laboratories.

During his freshman academic year, he may have no opportunity to enroll in regularly scheduled health education courses given as a part of his General Education. He overhears his friends discuss the incidence of measles, mononucleosis, typhoid fever, tuberculosis, virus infections, and emotional health disturbances among students. He would like to discuss the many aspects of problem drinking and of alcoholic beverages on an adult basis and not be "preached at" or "moralized." He would welcome an opportunity to become acquainted with adult health problems such as mental illness, family health, consumer health problems, diseases and accidents of adults, community health problems, and procedures during community-wide disasters. But, he may have no opportunity to enroll in regularly scheduled health education classes taught by school health educators who use objective information to discover the college student's health needs and health interests.

As he progresses through his undergraduate years, he may participate in a physical education program which does not take into account his physical health status. He may be enrolled in physical education classes where tests to determine his motor skills are not used and where adapted (or "modified") physical education may be excluded. His physical education classes may be so over-enrolled that he can seldom practice the skills he wishes to acquire for leisure time activities.

Also, he may suspect that there is little coordination between the professional health services staff and his faculty advisors. After a medical examination, he wonders if his faculty advisor has received any information as to his health deficiencies. For example, the health services personnel may detect signs of a hearing difficulty. This suspicion of the difficulty may be followed by pure-tone audiometer tests in a speech or hearing clinic or in a special education laboratory. But, that information of the hearing difficulty may or may not reach his faculty advisors.

If the student enters teacher-education, there may or may not be opportunities for him to participate in the college health pro-

gram. What are some ways by which the prospective teacher might participate in this health program?

1. a thorough medical examination at admission, at the end of the sophomore year and/or previous to student teaching.
2. a tuberculin test or chest x-ray annually and particiularly at graduation.
3. continuous faculty advisement with the assistance of the Counseling and Guidance Services to "screen out" students with emotional health disturbances.
4. screening the vision, hearing, and speech of students during the freshman year so that remediable health defects can be corrected.
5. health records, of participants in intramural programs, checked thoroughly so as to discover students whose health grade classification does not warrant participation.
6. continuous check upon the health status of the student by the health coordinator so that faculty advisors can be informed of deviations in mental and physical health.
7. complete cumulative records, on the mental as well as the physical health of the prospective teacher, designed to include a summation of the pertinent facts to be used by school employment officials.
8. physical education programs which utilize in their planning the health grade classification given by the family or college physician, physical education tests, and other screening.
9. basic personal and community health and safety education as a part of General Education.
10. professional teacher education courses in school health which provide learning experience in the functions of school personnel and which are taught by school health educators with appropriate teaching experiences.
11. a college environment that promotes sanitary measures and accident prevention so that all students and instructional and staff personnel can be exposed to conditons that assist in promoting healthful living.
12. college health council with broad representation from students, administrative and staff personnel, faculty, professional health services, and community health agencies so that the college health program can function effectively.
13. contact with the health coordinator who advises the student into the different areas of the college health program.

Yet, the Metropolitan Life Insurance Company reports in its monograph, "Fitness for Teaching," that student teachers are often selected by their academic records and not by evidence of their emotional stability and fitness in personal health. (6) One might ask the question — why?

College administrators are not too well informed as to the college health program. One of the purposes of the National Conference on Health in Colleges, held in 1931, 1936, 1947, and 1954, and stated in the publication, A HEALTH PROGRAM FOR COLLEGES (8), is to acquaint the college administrative and instructional staffs with the scope and objectives of the college health program.

College administrators visualize health programs as the responsibility of college physicians and nurses. These administrators generally do not accept college health programs which prevent disease and injury, which encourage correction of remediable health defects by family physicians and dentists, which assist in the health care and education of the handicapped, which include mental health, which provide sanitation and accident prevention for the college student and employee, and which eradicate the student's pseudo-information, superstitions, and faulty health practices. Research has disclosed the inadequacies in health knowledge of college students such as the studies by Kilander (4), (5) and Cambron (1), to name a few. While, the extent of secondary school health teaching has been revealed by Drury (2), the types of college preparation of high school health teachers has been divulged by Moorehead (7), and the variations of health education requirements for the certification of secondary school teachers has been disclosed by Haag (3). Unfortunately, college administrators are not familiar with the research studies in college and school health nor the morbidity reports, motor vehicle accident records, and the vital statistics which show the incidence of death to college youth.

Budgets dictate the effectiveness of any college health program. These budgets, designed by administrative staffs, can minimize the number of full-time physicians, nurses, and other college health services personnel. Budgets curtail the buying of necessary equipment and supplies in the many areas of the college health program. Budgets limit the possibilities of health coordination between the professional health services and instructional staffs. Budgets eliminate the position of the health coordinator, school health educator, and graduate assistantship in health education. Budgets determine the type and professional qualities of the personnel directing counseling activities. Budgets set the pattern of curricular offerings in health and safety education as a part of General Education and in professional school health education. Budgets can hamper the quality of health and safety instruction by forcing the instructor to use obsolete and ineffective teaching aids. Budgets provide the types of facilities used by the college health program. If the administrator is not well informed as to the college health program, he plans budgets which retard the development of the college health program.

In summary, the adult apathy encountered in school and community health programs may originate with the college ad-

ministrator's failure to understand the scope and objectives of the college health program, thus, limiting the college student's participation in his own program and his interest in school and community health programs as a parent, as a professional worker, and as a citizen.

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ANNOUNCEMENT OF LESTER TAYLOR SCHOLARSHIP

A $400 scholarship, named for the Health Museum's first president, is available to any qualified graduate interested in school health education, visual methods in health education, or educational work in museums. Special projects, tailored to the interests and requirements of the candidate, have been set up for completion in from one to three months. All projects must be done on the Museum premises under the supervision and direction of its professional staff, and a written report of the project(s) is required.

Applications for 1955 are now being taken. Address all inquiries to Bruno Gebhard, M.D., Director, Cleveland Health Museum, 8911 Euclid Avenue, Cleveland 6, Ohio. No applications will be considered after May 30, 1955.

THE ROLE OF THE ADVISORY HEALTH COUNCIL IN THE SCHOOL HEALTH PROGRAM

CARL C. FISCHER, B.S., M.D., F.A.C.P.
Professor and Head of the Division of Pediatrics
Hahnemann Medical College and Hospital of Philadelphia, Penn.
Chairman, Commission on School and Child Health
Pennsylvania State Medical Society

That active participation by selected representatives of community interests is necessary to the success of any activity involving the community as a whole has become increasingly recognized in recent years. That this should apply to an activity such as an adequate school health program would seem almost self-evident.

Perhaps a clearer view of the problem might be secured if we first focus our attention upon some acceptable definition of what a complete school health program might be. For this purpose, I have accepted Dr. Dukelow's definition that a school health program includes "the three arbitrary areas of health service, health education, and healthful environment." Obviously, such a threefold field of action could not be completely and adequately covered by professional workers in either the educational or the medical field or by their combined services alone.

The need for and value of Advisory Health Councils has long been recognized in school health circles as is testified by many references to them in the conferences on the cooperation of the physician in school health and physical education programs which have been held since 1947. Recommendations for the formation of such lay committees have been repeatedly brought forth and might be summarized by the statement in the charter for school health which states, "Every school should establish its own council or health committee."

In an effort to determine the extent to which such services were being utilized, Drs. Hein and Dukelow, consultants in Health and Fitness of the Bureau of Health Education in the American Medical Association, sent out a questionnaire in 1950 to all medical societies on the question of physicians and schools, and, pertinent to our particular problem was the question listed as number 2, in the questionnaire, viz., "Is there a school health council or committee (including a membership outside the school) within the area from which the medical society membership is drawn?" To

Presented before the American School Health Association at the meeting of the American Public Health Association, November 9, 1953, New York City, New York.

this question only 27% replied yes, 59% no, and 4% did not answer.

A follow-up to this question was the following: "A. Is there medical society representation on this council or committee?" Here we are astounded to find that only 24% said yes, 40% no, and 36% did not answer. Another question, "Are regular reports of the actions of the school health council made to members of the medical society?" resulted in the interesting reply that only 12% said yes, 60% no, and the remainder did not answer.

With this background, the Sub-Committee on Health of the Governor's Committee on Children and Youth of the State of Pennsylvania (a committee appointed by the Governor to follow-up the recommendations of the Mid-Century White House Conference) decided to look into the question of such advisory Health Councils to the schools system in the Commonwealth of Pennsylvania.

In that Commonwealth it is interesting to note that local Advisory Health Councils were authorized by Act 426 of the General Assembly of 1945 and then were made mandatory by Act 522 of the General Assembly of 1947. To the present time we have been unable to find another state in which the school health code made such Advisory Health Council mandatory, and we were interested, therefore, in noting the extent to which they were effective and the work which they accomplished.

It might be well first to note that by our law the district superintendents in school districts of the first, second, and third classes and county superintendents in districts under their supervision are directed to set up Advisory Health Councils to study the health needs and to assist in organizing a follow-up program. The law further specified that those making the medical and dental examinations make an annual report to this advisory council, and later make a report on the remedial work which has been accomplished during the year. Finally, it decrees "This advisory council shall be composed of representatives of medical and dental associations, social organizations, veterans organizations, parent-teacher associations, service clubs and other organizations in the area served."

With the cooperation, then, of the Departments of Education and of Health of the Commonwealth of Pennsylvania, questionnaires were sent to all the district superintendents responsible under this law for the creation of such advisory health councils. Of

the 275 queried, 23% replied. Of these, 50% reported organization completed, 11% in process, 5% the use of another kind of group and 34% that they had no council.

The Committee then decided that an attempt should be made to determine the scope of activity of those councils which were functioning as well as the directions in which their interests lay.

A second questionnaire was therefore sent out in May of 1952 and 65 of the Councils replied in detail. In reply to the question "Are you studying the health needs of the home, school, and community?", 95% replied yes, 4½% no, and one did not answer. As a corollary to that question we asked "What are your three most outstanding health needs in the order of their importance?" Here, we were most interested to note that a better dental health program including clinics, follow-up procedures, and dental education for parents took first place, with health education programs for the school, community, and especially parents (in respect to the correction of defects) second, and intensive follow-up with greater financial and treatment resources for the correction of defects, third. Other needs covering a wide gamut of possibilities were suggested, such as correction of visual defects, better school lunch program, better recreation facilities and glasses for those not eligible under the school health program. Improved immunization program, better mental health facilities, better equipment for health room, etc., made up the remainder.

We then asked these councils "Have you established objectives according to these health needs?" and found that, of those replying, only 70% had done so, 25% had not, and the remaining did not answer. When queried specifically as to what these objectives for the school year were, 17 listed correction of defects, 5 dental corrections, 5 the increase of equipment or establishment of clinic facilities, 4 the stimulation of community interest, 3 assistance for indigent or lax parents, and 3 obtaining better cooperation from parents and teachers.

Question four read: "Have you established a procedure for periodic evaluation of the home, school, community health programs?" In reply to this, 60% replied affirmatively and the remaining 40% negatively.

Question five read: "What assistance does the council give the school nurse with the problems, financial and other, encountered in arranging for correction?" In reply to this 23 noted that the school nurse helped in defraying the cost of corrections, 11 that

she provided consultation on problems of follow-up, 3 stressed the provision of equipment and transportation, and 2 publicity and public relations.

Question six read: "Describe projects you have been working on in the following areas. A. Healthful school environment." In this realm, the largest number (20) listed lighting improvements. Next, 13 listed heating and ventilating improvement; 9 new seating equipment, and 3 sanitary evaluation.

The second sub-group to this question was that of "B. Community health education." Here only 15 replied, 7 mentioning study, talks, and consultation with parents, 5 family life education classes in high school, and 3 adult classes in panel form.

The third sub-group of these projects was listed as "C. Stimulation of preventive measures." Here we found a great deal of activity, 41 reporting mass chest x-ray surveys, 24 safety education, 21 immunization programs, 16 publicity on fluoridation of water supply, 16 a nutrition program including school lunches, 1 a diabetes detection drive.

As to a question concerning special service programs, here a wide variety was reported; 7 noting speech correction classes instituted, 4 home-bound instruction, 3 sight saving classes, and 11 other special classes for specific purposes.

The final phase of this question concerning projects being worked upon, asked for other programs which might have been stimulated or initiated which were not covered by the above and here were included in the replies "first aid instruction for all school employees; 2, recreation programs; 3, organization of county health council; and 4, attempts to standardize the reporting of defects in city and council."

Our final question, which I think is of special interest, is "In what way do you believe the Governor's Committee on Children and Youth can be of most help to your School Health Advisory Council?" Here we had some 61 different answers which, however, mostly fell in the group of: 1. providing a means for exchange of information on organization programs and methods; 2, the provision of leadership and consultation on organization and program; 3, the supplying of health education materials; and 4, attempts to improve medical assistance policies and procedures, perhaps to make them more available to all communities.

This then would appear to be a report of the progress made under a mandatory system in the Commonwealth of Pennsylvania.

Having been advised that other states showing rather satisfactory progress in the field of the development and use of such councils were those of New Jersey and Ohio, I queried the responsible authorities in these states for information concerning their progress.

From Dr. Wilson Guthrie, Director of Health, Safety, and Physical Education of the Department of Education of the State of New Jersey, I learned that they had created a New Jersey Council for Improvement of School Health as an advisory group to the Medical Society of the State of New Jersey under the stimulus of the Women's Auxillary of that group. The State Council then worked to have county councils formed in each one of the 21 counties of New Jersey. These councils are not mandatory and are made up of personnel from all areas of community health.

From Sewell Milligan, Chief of the Public Health Education Division of the Department of Health of the State of Ohio, I learned the following. First, school health councils in Ohio are set up at all levels, including school districts, counties, and individual schools and that these have grown out of the needs and interests of the local area, accounting for the difference in levels of organization. For example, in one county (Hocking County) the County Health Council has developed a School Health Committee which has a representative from each school in the county. Secondly, Mr. Milligan estimates that not more than 25% of the units have developed active councils. Thirdly, he notes that they are voluntary and not mandatory, and fourthly, that the major interests seem to have been school health services; first aid and home nursing; school and home accident prevention and emergency programs; and finally that the value of these councils to the school health program has been varied but, on the whole, very worthwhile.

What then, you may well ask, does all this tell us?

It was the conclusion of our group which studied this problem that Advisory Health Councils are a most important part of a school health program but that, to date, they have been overlooked to a very large extent, even where, as in the Commonwealth of Pennsylvania, their formation is mandatory under the School Health Code.

Secondly, it became apparent that if they are to serve in the greatest possible way in furthering the whole school health pro-

gram and particularly the health education aspects of that program, they must be composed of representatives of all interested groups and not simply of the professional groups specifically involved in the examinations or the correction of noted defects.

Thirdly, we are interested to note the emphasis placed by these councils upon the need for better dental health facilities and their relative lack of understanding of the possibilities for general health education from such a program. Fourthly, it became apparent that specific problems, particularly those with monetary aspects, appeared to be more obvious and hence more readily grasped than the broader, less obvious phases of the program.

Finally, we were impressed by the failure of all but a few of these groups so far to make use of their opportunities in family and community health education and to emphasize to a greater extent the need for the development of special services for handicapped children in various spheres.

In conclusion then, it seemed to us that *Advisory Health Councils*, be they mandatory or voluntary, *can and should be a vital part of any complete school health program* and that such councils, when created, are badly in need of stimulus, inspiration, and guidance from organizations such as the A.S.H.A. toward the development of a complete program looking toward the triple goal of health service, health education, and healthful environment.

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GUEST EDITORIAL

One of the leading publishers of books in education opens his material regarding a new text for prospective teachers by stating:

"This book is based on the assumption that a complete mastery of subject matter is the prime requisite for successful teaching."

Here pops up the head of a situation that becomes more serious year by year, until the publishers themselves are emphasizing in their advertising material itself the importance of scientifically accurate content as a fundamental of good teaching. We get the concept that the scientific content of subjects in education is under constant pressure to emphasize factors other than facts.

Less and less, efforts to *learn* are emphasized. We are told that students must be taught to think, although less and less we strive to get *facts* into their heads about which, or with which, to *think*. Texts based on facts — histories, for instance — contain fewer and fewer facts and more and more philosophizing.

Grave errors in facts are brushed aside as inconsequential, the publisher merely stating that the next edition will have a correction, and apparently the editors use little effort to disclose the why of the error or the reason for the author's carelessness, or in fact to discover the error itself. Why did not the publishers' readers discover the error?

A reviewer repeatedly runs into these errors, — errors that to the well informed person seem inexcusable. The discovery of these errors causes the reviewer to wonder how many other errors are in the text, which others may discover. What should the reviewer do — ignore the error, blast the author and editors for not discovering it, or refuse to review the text at all?

While we realize that perfection perhaps is impossible, nevertheless, some of these errors show a fundamental lack of information that makes one wonder if the author is competent in other fields of knowledge within the scope of the text.

We have, too, the author who — having perhaps built his theory on flimsy evidence — seeks to prove his statements by reiterated assertion. His foot-of-page references seek to prove these by referring to material written by him and published in an earlier edition. He not only shows gross conceit, but accepts former appearance in print as proof. How silly can we get?

This is the fallacy on which much of the false advertising depends. These advertisers apparently depend on the slogan —

"Reiteration is the thief of judgment." Some educators also seem to follow this line.

Moral: Read and listen with an alert mind.—*C.H.K.*

* * * * *

MEETINGS

J. A. Myers, M.D., Chairman of our Tuberculosis Committee has been asked to appear before the annual meeting of the Pennsylvania Tuberculosis and Health Association to explain the tuberculin testing and certification program of the American School Health Association.

He has also been invited to address the St. Louis Academy of General Practice at their annual meeting and discuss the same subject.

His Committee has arranged to hold an evening session of the American School Health Association in conjunction with the annual meeting of the National Tuberculosis Association Meeting in Milwaukee on May 22. Our members are urged to attend this session.

* * * * *

The Des Moines, Iowa, and Aberdeen, South Dakota, schools are engaged in the Tuberculosis Certification program this month. Interest seems to be developing fast in our tuberculosis testing program.

* * * * *

Illinois Tuberculosis Association has announced the allocation of $11,938 in grants to finance TB research projects at the University of Chicago and Northwestern University. Funds were provided through voluntary contribution of Christmas Seal Sale monies from county tuberculosis associations in Illinois.

An additional $1,000 of the fund was allocated to a cooperative study in 20 pediatric centers throughout the county to determine whether the administration of isoniazid to children with first infection tuberculosis will prevent them from developing TB meningitis. This study is being supported by grants from the U. S. Public Health Service's National Institutes of Health and the National Tuberculosis Association.

Additional grants for TB research in Illinois will be awarded by the ITA after June 1, the next deadline for submitting applications.

* * * * *

The next meeting of the American School Health Association will be held in Kansas City, November 14-18, 1955.

PARENTS ALERTED TO "STREP" SYMPTOMS TO HELP GUARD AGAINST RHEUMATIC FEVER

A "When to Call Your Doctor" checklist is provided for parents by the American Heart Association as part of the "Stop Rheumatic Fever" campaign which is being conducted in cooperation with the National Heart Institute of the United States Public Health Service. The checklist, which appears in the booklet, "Now You Can Protect Your Child Against Rheumatic Fever," contains seven key questions designed to alert parents to the possible presence of the most common forerunner of rheumatic fever, "strep" sore throat. The questions are:

1. Did the sore throat come on suddenly?
2. Does your youngster complain that his throat hurts most when he swallows?
3. Does it hurt below the angle of the jaw when you press there gently with your fingers? Are the glands swollen?
4. Does he have a fever? (Usually a "strep" infection brings on a fever between 101 and 104 degrees.)
5. Does your child complain of headache?
6. Is he nauseated? Has he vomited?
7. Has he been in contact with anyone who has had scarlet fever or a sore throat? (Any child who has been exposed to scarlet fever should see his doctor for preventive treatment.)

The leaflet points out that a youngster with a streptococcal infection is not likely to have all of these symptoms, but it urges calling a doctor if some of the danger signals are present, since only a doctor can diagnose "strep" and start immediate treatment if necessary.

* * * * *

DENTAL HEALTH

In his annual report to the Division of Health and Hygiene of the Cincinnati Public Schools, Cincinnati, Ohio, the Director, W. K. Streit records the following interesting observations concerning the control of Dental Health through Education in the Cincinnati Schools:

"The health education program in the elementary schools consists of an annual dental examination, classroom lectures and follow-up to find out how many children are going to the dentist, auditorium lectures, poster contests, circulating library of dental health education posters, dental report cards and letters to parents, instruction material to teachers, awards of banners to classrooms, and individual awards to children, dental progress charts for classrooms and many dental health projects conducted by the teacher on her own initiative.

The report of the dental examination for elementary school children shows no appreciable change in dental conditions during the last year, but it indicates we are maintaining the benefits that have been achieved over a good many years. Some interesting figures indicating the improvement in dental conditions found among school children in Cincinnati are as follows:

A decrease in the number of children with defective teeth from 87% to about 74% in a period of fifteen years.

The percent of children with six year molars missing has been reduced from 15% to 9% in fifteen years.

The number of six year molars missing per 100 children has been reduced from 25 per 100 children to 17.5 per 100 children.

Defective teeth per child have been reduced almost 50% from 6.2 per child to 3.8 per child in fifteen years.

The percent of children with perfect teeth has increased in fifteen years from 3.2% to 8.8%.—*A O. DeWeese.*

* * * * *

DEATH OF FAMOUS EDUCATOR

Mrs. Winifred Hathaway, world-famous educator and leader in efforts to insure adequate educational opportunities for America's 60,000 partially seeing children, died December 1, 1954, in New York after a short illness. She was 83.

Educational procedures now employed generally throughout the United States for the partially seeing follow patterns which she actively promoted, starting in 1916, when she joined the staff of the National Society for the Prevention of Blindness.

Before Mrs. Hathaway undertook her campaign, many partially seeing children were regarded as blind, thus preventing them from taking full advantage of whatever degree of sight they enjoyed. Others, whose eye conditions were not fully understood, found themselves unable, solely for reasons related to vision, to "keep up" with their classes.

* * * * *

REPRINTS AVAILABLE

Reprints of the address by Dana L. Farnsworth, M.D., on *Mental Hygiene—Keystone of Education,* delivered at the Annual Meeting of the ASHA in Buffalo in October, 1954, may be obtained free of charge by writing to the School Health Bureau, Health and Welfare Division, Metropolitan Life Insurance Company, 1 Madison Avenue, New York 10, New York.

EXPERT COMMITTEE ON HEALTH EDUCATION OF THE PUBLIC (WHO)

First Report

Increasing attention is being given to health education as an essential part of all efforts to improve health and general welfare. Health education encompasses much more than instruction in health practices, encouragement of the use of health services, and promotion of specific health projects, although all these are within its province. Rightfully understood, it enters into many aspects of daily living, with numerous opportunities being afforded in family and community activities for direct or indirect learning about health. Such opportunities and ways of taking advantage of them are among the subjects considered in the first report of the WHO Expert Committee on Health Education of the Public.*

This first report is considered "an introductory study of health education as an aspect of health work, common to many different activities". It emphasizes the necessity for adapting health education to the educational, social, economic, and cultural conditions of different countries, and for studying a population thoroughly before embarking upon a health education programme.

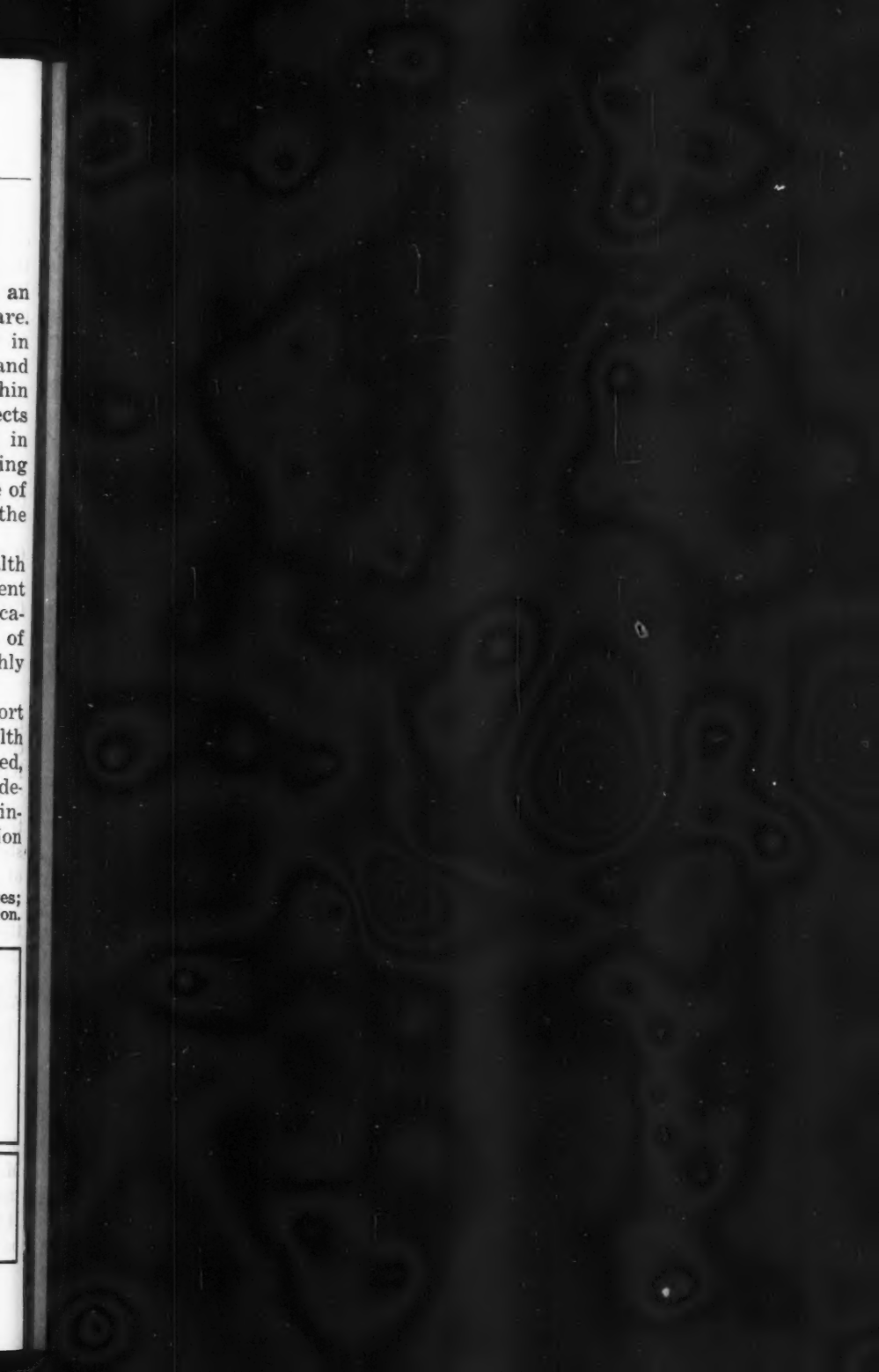
Although it is not a detailed study of techniques, this report provides much information on the guiding principles of health education; suggests how programmes should be planned, organized, and evaluated; outlines the factors involved in the selection, development, and use of methods and media; and discusses the training of personnel engaged, directly or indirectly, in health education of the public.

* *World Health Organization*: *Technical Report Series*, No. 89, 41 pages; price: 1/9, $0.25, Fr. fr. 80, Sw. fr. 1. — Available also in a French edition.

P.T.O.

WANTED

PUBLIC HEALTH NURSE — For Teacher of Public School Health position in Chicago Public Schools. 6-hour day, 5-day week, 40-week year. Annual salary with Baccalaureate Degree, minimum $3400, maximum $5650; with Master's Degree, minimum $3650, maximum $6150. Salary increase expected September 1, 1955. Salary adjustment for previous experience allowed following certification. Require Baccalaureate Degree and program of study in Public Health Nursing, plus one year's experience in community nursing. Reply to Madeline Roessler, Supervisor, Chicago Public Schools, 228 N. LaSalle St., Chicago 1, Illinois.

WOMEN'S INTERESTS — PINKING SHEARS

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